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June , 2002

Mike Fiore
Director, Division of Integrated Health Systems
Family and Children's Health Programs Group
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Mr. Fiore:

Arkansas is requesting a five year extension of the Family Planning, to be named Women's Health 1115 demonstration, Project Number, 11-W-0074/6.

This request has been developed in conformance with the Centers for Medicare and Medicaid Services' guidelines. If granted, the extension period will run from September 1, 2002 through September 30, 2007.

We look forward to your response. If you have any questions or need additional information, please contact Carolyn Patrick at 501-682-8359 or Carolyn.Patrick@Medicaid.state.ar.us.

Sincerely,

Ray Hanley,
Director

Cc: Calvin Cline, Associate Regional Administrator, CMS, Dallas Regional Office
Pam Forton, CMS, Baltimore Central Office
J.P. Peters, CMS, Dallas Regional Office

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

REQUEST FOR EXTENSION OF THE FAMILY PLANNING
TO BE NAMED WOMEN'S HEALTH
1115 DEMONSTRATION
PROJECT NUMBER 11-W-00074/6

Submitted to:

Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted by:

Arkansas Department of Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, Arkansas 72203

June 2002

Women's Health Waiver Extension Application

A. Supporting Documentation Provided by the State.

I. Program Objectives:

The State shall reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

The primary purpose of the family planning demonstration waiver is to reduce unintended pregnancies in the project population and thereby reduce the number of births in Arkansas paid for by Medicaid. The State of Arkansas requests this extension of the waiver because the waiver has been successful in achieving this goal and because it is a critical component of the State's efforts to continue meeting the health needs of Arkansas women. Arkansas now considers the "Family Planning Waiver" to be a "Women's Health Waiver", as this more accurately reflects the scope of the services under the waiver.

Evaluation of the Waiver shows that at the end of the third year of the demonstration, the Family Planning Waiver achieved a net reduction in Medicaid expenditures of approximately $4.7 million. Though this is a significant reduction the benefits of the Waiver go well beyond monetary savings. The Waiver not only provides family planning services but also many other essential services to low-income women. A network of public and private providers has taken part in the Family Planning Waiver. A total of 65,435 women have used the services under the Family Planning Waiver in the first three years. Because Community Health Centers, private physicians, and Arkansas Department of Health clinics all can participate in the Waiver, routine primary and preventive care above and beyond contraceptive services have been available to Arkansas women. These primary and preventive services address the majority of routine health needs of women of childbearing age. Many of these are detailed in subsequent sections.

Arkansas requests that this Waiver be extended for five years plus one month to cover the period of September 1, 2002 through September 30, 2007 and that it be expanded to include women between 133% and 200% of the federal poverty level. This request is due to the success of the Waiver and to match the increase in eligibility of maternity services under Medicaid. This will help Arkansas address the needs of many low income and working poor women that do not have access to fundamental primary and preventive health care.

It has been well documented that lower-income women are more likely to have unintended pregnancies than their counterparts with higher family incomes. In addition they suffer a disproportionately higher number of other health-related problems. This is a significant problem in Arkansas where 17% of women aged 14-44 are living in poverty and 21% do not have private health insurance or Medicaid. This number is likely to increase due to the down turn in the economy and recent layoffs and plant closures in the state.

One of the results of this large number of women living in poverty and not receiving family planning services is that more than half of all live births in Arkansas are unintended and 15% of all live births are unwanted. This is particularly troublesome in Arkansas' teenagers and results in a pregnancy rate in this population that ranks 8th highest nationally. It should be noted however that prior to the waiver implementation, this ranking was second in the nation. There are 108 pregnancies annually per 1,000 women aged 15-19; 70% result in live births and 15% result in abortions. These numbers indicate that though the Waiver has been successful there are still many Arkansas women in need of family planning and other health services.

An independent evaluation was conducted by the Arkansas Center for Health Improvement (ACHI). Attachment I outlines their findings and recommendations. ACHI used a variety of sources including key informant interviews, program reviews, and extensive data analysis and review in their evaluation. The ACHI interim report recognizes a number of added benefits to women in the services they have received as a result of the waiver. They found that the Waiver has had an important effect on the detection and treatment of sexually transmitted diseases (STDs), provided important services to women who became pregnant, and fulfilled its primary mission of extending family planning services to a large number of women in Arkansas.

Arkansas sought to meet the following six objectives through the Medicaid Family Planning Waiver. The progress made towards achieving each goal is summarized below. Plans to further expand and improve on the progress towards these goals are also included.

1. **Increase access to and use of Medicaid paid family planning services for women of childbearing age:**

   The need to increase access to Medicaid family planning services for women of childbearing age has been well documented. The year before the start of the Arkansas Family Planning Medicaid Waiver, the Title X funded family planning program was half a million dollars short of affording the contraceptives requested by the women being served in their clinics. At that time, the Arkansas Department of Health (ADH) was able to make up the shortfall through other resources. Declining income from other ADH services and shortfalls in state revenues resulting in budget cuts would make this impossible now.

   It is readily apparent that the waiver has allowed the State to meet this objective and increase the number of women who obtain family planning services under the state's Medicaid program. A total of 65,435 women have used the services under the Family Planning Waiver in the first three years. The total number of eligibles in the first three years exceeded the total projected for the entire demonstration period by 27%. Outreach and enrollment have been tremendous program successes.

   Prior to the implementation of the waiver, only women with very low incomes would qualify for Medicaid and receive family planning services. However, the data indicate that relatively few women took advantage of this service. In fact the number was so low that it was not included in the annual report of the division responsible for the Arkansas Medicaid program.

   The ADH and the Arkansas Department of Human Services (DHS) undertook a number of steps to ensure the success of this objective including producing brochures explaining the waiver, its benefits and how to participate, (Attachment II). These were placed in all DHS County offices and ADH Clinics.

   The DHS Division of County Operations (DCO) is responsible for enrolling women in the Family Planning demonstration Waiver Program. DCO has offices in each of Arkansas' 75 counties to handle these applications as well as other services. DCO has trained staff in each ADH clinic on eligibility requirements of the program. DCO offices provide information to women on the services they are eligible for under the Family Planning Waiver when they apply for other assistance such as food stamps, regular Medicaid and Transitional Employment Assistance (Arkansas' Transitional Assistance for Needy Families [TANF] Program).

Both DHS and ADH made special efforts to counsel pregnant women who were receiving Medicaid prenatal care and delivery services about the waiver. Women were told about services they could receive with the Family Planning Waiver and how to apply for them. ADH clinics took applications and made preliminary determinations of eligibility. Women deemed eligible received services at ADH clinics the same day. Once enrolled, women are free to choose either public or private providers. With the Women's Health Waiver extension, Arkansas is now proposing to extend enrollment capability to all providers.

The ADH has recently reorganized to further their goal of providing programs tailored to meet the particular needs of a community. In order to accomplish this goal, the administration of the Department was divided into five regions. (A map of the regions and location of ADH clinics is provided in Attachment III.) This allows each region and ADH clinic within the region to determine the most effective way to serve their clients. The evaluation shows that local health units are making significant efforts to advise all persons using other ADH services of the availability of the services provided under the waiver.

Experience serving low income women of childbearing age has taught ADH clinic personnel that extra efforts are needed to assist and encourage these women to present for their appointments and follow through with the services they choose. ADH staff makes every effort to remind women of upcoming appointments. Follow-up calls and home visits are made when needed to see that the needs of the client are being met and to help remove barriers to participation. An automated infrastructure has been initiated to enhance compliance. ADH purchased computers and special software for each clinic to provide appointment reminders and track clients. To date the program has been in place the longest and with the greatest success in the Southwest Region. It is followed closely by the Northwest Region. The other three Regions are in the process of conducting training on the use of the software and implementing the program. It is expected to be fully operational in the year 2003.

Currently the largest community-based outreach and care coordination program utilizing Family Planning Waiver dollars is in place in the Southwestern Region of the state. It includes telephone reminders, transportation, childcare, and outreach to the community. Each of the other four regions will have an opportunity to see the results of this effort and determine if a similar program would increase the use of subsidized family planning services in their region. They will also have the opportunity to customize the program to meet the unique needs of their communities.

Another essential component to improving access to family planning services is to partner with others to ensure this care is available. Many areas of Arkansas are designated Medically Underserved and Health Care Manpower Shortage Areas. Therefore, a primary provider of care in many areas of the state is a Community Health Center (CHC). Arkansas is fortunate to have a number of Community Health Centers that provide quality preventive and primary care to its citizens, (See Map in Attachment IV). The ADH has enjoyed a long-term positive working relationship with the Community Health Centers in the state. They have worked together to provide the best care possible for Arkansans.

Recognizing the important role Community Health Centers play in many key areas of women's health the ADH has entered into a formal agreement with the Community Health Centers for referrals for women's health services. (A signed Memorandum of Agreement between the ADH and the CHCs is included in Attachment V). The Department's toll free Health Information Line also provides referrals to Community Health Centers and private physicians.

Copies of the Community Health Center brochure (See Attachment VI), or similar printed pamphlets, which identify the location of all 46 clinics in the State, will be provided to female clients at local ADH clinics and DHS offices. The brochure describes primary and preventive care provided by the CHCs. Clients will also receive oral counseling about the availability of primary and preventive services through the CHC sites. This counseling will be part of the counseling standards used by ADH and noted on client's records.

Realizing that different messages and methods are needed to reach different women, other point of service advertising methods are currently being considered and will be developed for use at ADH, DHS and CHC sites.

In some geographical areas of the state private providers and CHC clinics are not readily accessible to women. In these areas the Department of Health will make every effort to develop formal referral agreements with Federally Qualified Rural Health Clinics (FQHCs) and Arkansas Health Education Centers (AHECs), to ensure increased availability of services for Arkansas women. The FQHCs are not organized on a statewide basis and agreements will need to be individually developed. FQHCs and AHECs are presently listed in the Resource Referral Directory. The directory lists health and other service providers in each county and is used by the ADH toll-free Resources and Health Information Line.

Adding providers and formalizing agreements alone will not increase access to needed services by the Medicaid population. ADH will spearhead a coordinated education and information campaign on the waiver, enrollment and referral process to educate providers. A number of methods and outlets to provide this information will be used. The education plan will include an ongoing evaluation strategy to determine which methods are most successful. Adjustments will be made as needed to ensure that the most successful methods are used.

One component of the plan will include outreach seminars for doctors and other practitioners. One example of this would be presentations and exhibits at the Medicaid Managed Care Services regional meetings. Medicaid Managed Care Services is a Division of the Arkansas Foundation for Medical Care; they provide educational opportunities for Medicaid providers. In addition to outreach, the regional meetings will provide opportunity for training and best practices dissemination, regarding the waiver and reproductive health.

Recognizing the need to maintain confidentiality ADH utilizes the Request for Information/Release Form (CHS-3) to exchange patient information between local health units, regional offices and central office. It is also used to exchange medical information with private providers and CHCs.

2. Decrease inadequately spaced pregnancies among women in the target population (Inadequately spaced – less than 2 years):

The negative impact of inadequately spaced births on infant outcomes is well established. The Evaluation of the Family Planning Demonstration Waiver prepared by the Arkansas Center for Health Improvement (ACHI) tried to determine if the waiver significantly reduced the probability of a conception following the birth of the last child in women who participated in the waiver program. For comparison they used a control group of similar women not exposed to the wavier and waiver participants. The goal for the comparison was to find a sample of women in the same income category that were not users of the waiver even though they were eligible. The women in this group were all pregnant or 60 days postpartum between September 1996 and September 1997.

The evaluation report notes that the selection of the control group of non-waiver women introduces some bias into the data. For example, women participating in the waiver were not necessarily pregnant or 60 days post-partum in the same time frame. Thus analysis of the waiver women was restricted to match criteria for non-waiver women. The report also points out that there were differences in the two groups that might have impacted the outcome such as those in the waiver group was more rural than the non-waiver group. Keeping in mind that there were some limitations to the study, the findings showed that the difference between the waiver and non-waiver women was negligible.

This analysis provided inconclusive results on the significance of the Family Planning Demonstration Waiver on fertility. This may be because any true effect could not be observed because women self-selected into the waiver program. There is no way to know whether or not these women would have been as successful in spacing or limiting their births if the waiver program had not been in place. Other facts that could obscure any underlying program effect include the likelihood that some women on the waiver were not new users, but rather were switched from another payment source to Medicaid. Thus, women who were already motivated to use contraception and who had financial coverage for such services were simply moved from one source of funding to another. Under these circumstances, any change in behavior would not be expected. Future program efforts such as plans to allow private providers to enroll women as well as increased educational and referral efforts are expected to enlist women who were not already in the system or not motivated to control their fertility through education and outreach programs.

However, this is a significant success for the waiver. If these women were motivated to extend time between pregnancies, but had not had access to the services through the waiver, they might not have been successful.

Despite an expected increase for all age groups in the number of births and pregnancies, based on ratio analysis and increase in the population of women, 500 fewer pregnancies than expected occurred by 1998. Most averted pregnancies were in the 14-19 year age group and the 20-24 year age group. The increase in averted pregnancies was even larger in 1999, with 1,400 pregnancies averted. Despite a spike in the age group from 20-34 in 2000, expected teen pregnancies continued to fall, with 376 pregnancies averted. These averted pregnancies occurred despite 51 more pregnancies than expected occurring in 1997 relative to 1996.

This is also considered an accomplishment of the waiver. Averting pregnancies, particularly in the 14-19 age group is key to not only improving the health of teenage girls, but also to breaking the cycle of teen mothers who are not able to be self sufficient and would likely rely on public assistance such as TANF.

The evaluation found that women in the waiver group had lower conception rates because of self-selection and dramatically lower fertility rates occurred during the waiver program for both groups because subjects were selected on the basis of a live birth just before the waiver program began.

The evaluation concludes that women should be followed for a longer time period to allow longer-term effects of the program to appear. It also recommends that a sample be used that was not restricted to women who gave birth the year before the study began. This is complicated by the need to identify women in a similar income bracket. Finally it notes that future program efforts might include more aggressive methods to enlist women who were not already in the system or not motivated to control their fertility through education and outreach programs.

3. Decrease the number of Medicaid paid deliveries (Resulting in a decrease in annual expenditures for prenatal, delivery, newborn and infant care):

To evaluate any decrease in deliveries paid for by the state Medicaid program, rates of pregnancies and births paid for by Medicaid were examined for the evaluation. Calculation of pregnancies and births paid for by Medicaid also used claims data supplied by the Division of Medical Services of DHS. The data show that the number of pregnant women receiving services paid for by the Arkansas Medicaid program decreased by approximately 500 births over the period from 1996-1999. Most of the reductions in pregnancies occurred in the youngest age group (teenage pregnancies). As noted above, this is a significant accomplishment in itself.

The data also shows that the number of women with delivery services paid by Medicaid declined over the 1996-1999 period for most age groups. Thus in meeting the goal of the waiver to decrease Medicaid paid deliveries, the State also met the secondary goal of decreasing the annual expenditures for prenatal, delivery, newborn and infant care.

4. **Increase the use of subsidized family planning services by women in need of subsidized family planning services in Arkansas (Including women served through Titles V and X and state funds):**

ADH obtains funds from four primary sources to support its reproductive health program: the Maternal and Child Health Block Grant (Title V); the Family Planning Project Grant (Title X) and related fees; Medicaid waiver, and state fund appropriations. The Title V funding and the state fund appropriations provide for the equipment and facilities for the program. State funds also contribute the salaries of those working in these programs. Title X provides money to serve patients who do not qualify for Medicaid. It also sets the guidelines for Family Planning.

The use of subsidized Family Planning Services by women who need them has increased significantly since the implementation of the waiver as evidenced by the numbers reported in Objective 1. However, the benefits are more far-reaching due to the other efforts to increase the number of subsidized family planning services provided to women in Arkansas. These are also summarized below.

The Arkansas Departments of Health and Human Services work in conjunction with a number of other organizations to increase the number of subsidized family planning services available for hard to reach populations of women in the state.

- The Arkansas Birthing Project began in June 1999 following an authorization of the Watershed Human and Community Development Agency by the Birthing Project USA. It uses community volunteers as mentors to provide emotional, social, and practical support to teenage mothers and for up to one year after pregnancy. A Sister-Friend, the Project's name for the mentor, assists the woman in obtaining prenatal care services, getting access to other health resources such as WIC, immunizations, and family planning services, and identifying other basic community resources. From July 2000 through June 2001, 55 women were enrolled in the program. It is operating in collaboration with the local TANF coalition and the ADH Teen Pregnancy Prevention initiative. By targeting teens that already have one child, this project also addresses the birth spacing objective of the waiver.

- ADH is also supporting the Promotoras Health Program operated under the auspices of the Arkansas Human Development Corporation. The program targets the under-served Hispanic/Latino population in Pulaski, Saline, Lonoke, and Faulkner counties in central Arkansas. The focus is on health education, disease awareness, and prevention education with special emphasis on teen pregnancy, HIV/STDs, tobacco use, cancer, diabetes, and hypertension. During the decade of the 1990's, Arkansas reported a higher percentage increase in Hispanic residents than any other state in the country.

- During the 1997 Arkansas Legislative session, the Arkansas Legislature allocated state funding to be used for a teenage pregnancy prevention media campaign. Based upon technical assistance provided by the National Campaign to Prevent Teen Pregnancy, a local campaign entitled "The Future is Yours" was developed. Targeted paid and in-kind television and radio spots ran statewide for six months in 1999. This effort led to a previously discussed increase in information line usage. A second campaign targeting parent/child communication was aired for three months in Central Arkansas.

- The Institute for Survey/Business Research Group of the Institute for Economic Advancement at the University of Arkansas at Little Rock did an evaluation of the 2001 campaign for ADH. The evaluation consisted of telephone interviews with parents or guardians of children age 11 to 18 who lived with them. The results revealed that Central Arkansas parents/guardians are making the effort to inform their children on the consequences of sexual issues. The majority of the respondents indicated that the "The Future is Yours" public service announcement (PSA) was highly visible and memorable. Results indicate that ADH has been successful in informing Central Arkansas residents about their role in encouraging communication between parents and children on sexual issues.

- The TLC Nurse Home Visiting Program was implemented in 15 counties in four regions of the state in January 2000. This program was modeled on the David Olds Nurse-Family Partnership. It was terminated in June 2001 as a result of a budget shortfall. Clients were teenagers between 15 and 19 years of age who were expecting their first child. Nine prenatal visits were scheduled for each, and public health nurses were scheduled for home visits twice a month after delivery. During the time this program was in place, these mothers were encouraged to use family planning services to prevent unplanned and inadequately spaced pregnancies. Four hundred sixty eight expectant teens were served in the program. This program specifically addressed the waiver objective to affect spacing of repeat pregnancies.

- The ADH central office is responsible for customer education. Staff from this office holds public forums throughout the state, usually in conjunction with churches and community groups. Currently, there is a pilot program underway with the inmates of the Jefferson County jail in Pine Bluff. Health educators provide additional customer education in each geographic region of the state.

- The ADH Resources and Health Information Line is a statewide, confidential, toll-free, information system that operates 24 hours a day, seven days a week. It is staffed with employees trained to provide callers with immediate information and referrals about reproductive health services available in the state from its computerized resource directory.

  Questions about family planning have consistently remained the largest percentage of all requests for information or referrals the Hot Line receives. In some years, those inquiries run over 90 percent of the total requests. On-going outreach to populations with special needs including counseling for young people is provided by ADH. The ADH Policies and Procedures Manual provides guidance to all of its clinics. The section on Reproductive Health Counseling Standards contains the following guidance:

"All unmarried teenagers seeking reproductive health services at ADH clinics are informed on the following issues:

- Review of the human reproductive system
- Review their understanding of fertility and conception
- Stress that abstinence is the surest method of avoiding any risk of pregnancy and/or sexually transmitted disease
- Encourage discussion of decisions regarding sexual activity and contraceptive use with her parents, as they would discuss any decision affecting her health and well being.
- Ask if teen has considered discussing or has already discussed this decision with his or her family. The final decision is up to the teen, and services are provided regardless of the decision."

- ADH also works with public schools when invited by local authorities. Three persons on staff share the responsibility for this work and travel throughout the state. They have continuing relationships with a number of schools throughout the state. The most successful is with Central High School in Little Rock.

- Male Reproductive Health Services – ADH has established a male clinic in West Helena that addresses the family planning needs of males as well as the prevention of sexually transmitted diseases.

- Prior to the Family Planning Waiver, vasectomies were available from ADH primarily through physicians on its staff who were willing to perform them. In the early 1990s, ADH reported between 40 and 75 such operations annually. Since the waiver began in 1997, that figure has risen to over 100 per year. ADH now has arrangements to provide this service with the University of Arkansas for Medical Sciences, the Area Health Education Centers (AHEC) in Fort Smith, Fayetteville, and Jonesboro, and private physicians in Prescott, El Dorado, and Mena.

- Coordination with Unwed Birth Prevention Programs. Reimbursement from the Family Planning Medicaid Waiver is used to support two distinct teenage pregnancy prevention programs – abstinence education and unwed birth prevention. Since 1997, a range of 14-22 local abstinence efforts has been supported annually through a competitive request for proposal process. An independent evaluator evaluates individual grantees. Unwed birth prevention funds support local coalition building in the 15 Arkansas counties with the greatest number of unwed births for the past five years. Projects are required to develop broad-based coalitions including teens to inventory local prevention efforts and stimulate local development and support of new initiatives, which fill identified gaps. An independent contractor provides grantee technical assistance and project evaluation. The activities of the Family Planning Waiver are coordinated with these programs through the Women's Health Team of the ADH.

  In 2001, Arkansas was one of three states to receive a Community Based Abstinence Education Grant totaling $800,000 a year for three years. This award enabled the state to start eleven additional abstinence education programs.

  Notification to Applicants for State Services – As noted earlier, both the ADH clinics and the DHS county offices have directives that require them to let applicants for other programs know about the Family Planning Waiver if it seems likely that they would need the service and/or qualify.

- Materials in Spanish. ADH distributes Spanish versions of general materials on family planning issues and methods. All the applicant forms are also in Spanish. However, the Family Planning Waiver brochures are not yet available in Spanish. Many of the Arkansas Department of Health county units have interpreters available to provide this service to Hispanic clients.

With the ADH's shift to a philosophy designed to include local communities in determining their health care needs and the best way to meet them, many communities are identifying the need to improve the quality and availability of materials in Spanish. They are partnering with ADH to develop and fund the publication and distribution of these materials. Some parts of the State are also experiencing influxes of other populations that will require culturally sensitive and or language appropriate materials. ADH and DHS personnel will monitor this situation and materials will be developed as needed. Private providers and Community Health Centers will be included in these studies to determine their needs in this area.

5. Improve the availability of family planning services for the Arkansas Medicaid population.

The initial projection of eligible women to be enrolled in the family planning waiver was 60,750, which was actually less than the 65,435 women who became waiver participants in the first three years of the program. Overall, the number of persons served in the third program year increased by 31.5% from the year prior to the beginning of the waiver program.

Another significant finding of the evaluation relating to availability of services can be seen in the total number of providers which increased 11.7%, from 732 in the first program year to 818 in the third program year. All of these increases occurred among private service providers, who increased 16% to 718. Solo and group practitioners constituted slightly more than 71% in PY3. In general, increases in provider availability occurred in more populous counties. It is clear that in some rural counties and Delta counties there is still a need to increase availability of providers. However, this is not a problem that will be totally solved by the family planning waiver. But, it can, if extended, be a part of the solution for these underserved rural areas.

As part of the waiver extension, DHS and ADH have determined that another way to improve availability of family planning, primary and preventive services is to let private providers enroll patients into the Women's Health Waiver. This should increase the number of providers participating in the waiver and the number of patients served by the waiver. This will involve increased outreach to private providers to inform and educate them on the waiver and enrollment procedures. DHS currently publishes a quarterly newsletter to private providers. It includes best practices and other information regarding the waiver. This will be an important avenue, as well as the regional meetings for Medicaid providers previously mentioned, in reaching additional private providers and enlisting their participation in the waiver.

There are a number of areas in Arkansas where nurse practitioners are primary providers of family planning and other primary and preventive services for women. Increased efforts are planned to educate them on the waiver, enrollment procedures and the benefits it can offer their patients. One important way we will reach this group of practitioners is through their regularly scheduled meetings.

ADH created a vasectomy referral program using funds freed up under the Title X program. Sites include Little Rock, El Dorado, Prescott, Mena, Jonesboro, Fort Smith and Fayetteville. Additional sites are to be added. In addition to this effort and those already mentioned under other objectives in 1998 each of the ten Health Management Areas developed local plans to improve both access to and the effectiveness of family planning. They concentrated on redirecting family planning efforts to regional initiatives designed to meet the unique needs of the region. Following restructuring of the Department to allow for more local control and adaptation of services to meet local needs, these plans are being evaluated by the five regional teams. Adjustments are being made to better meet the needs of the individuals in each region.

Prior to the Waiver few Arkansas women were able to choose sterilization as a form of birth control. Publicly funded sterilization was primarily available just to women who qualified for the regular Medicaid program or were in the 60-day postpartum period after a Medicaid-funded delivery. In the first three years of the waiver, 5,699 women chose sterilization [8.7% of recipients].

6. Offset the expenditures under the waiver with reductions in other Medicaid expenditures.

Calculations for cost offsets associated with the family planning waiver follow definitions and formulas approved with initial waiver application. Because effects of family planning activities are not immediately reflected in reproductive statistics, the Centers for Medicare and Medicaid Services (CMS) agreed to delay the initial evaluation until at least the second year after the demonstration had been completed. The costs to the Arkansas Medicaid program are considered from provision of services under the family planning waiver against cost savings generated from reduced pregnancies and births paid for by the Arkansas Medicaid program. These cost savings from reductions in pregnancies and births were restricted to four categories of cost: prenatal care costs, delivery costs, infant Medicaid costs in the first year of life, and disabled infant costs in the second year of life. All cost figures were calculated from claims data supplied by the Division of Medical Services. Information on the gross number of pregnancies and births paid for does not permit calculation of averted events. To calculate pregnancies averted, a rate had to be formed in the base year that could then be applied to subsequent years.

The evaluation found that overall 51 more pregnancies than expected occurred in 1997 relative to 1996. This changed dramatically by 1998, when there were more than 500 fewer pregnancies than expected. As noted above and elaborated on further in this section it is significant that most of the pregnancies averted were in the lowest age group (14-19) followed by the next lowest age group (20-24). An even larger increase in pregnancies averted occurred in 1999, consistent with expansion of the family planning waiver program. In calendar year 1999, the ratio analysis estimated that more than 1,400 pregnancies were averted, with most of them occurring in the youngest age groups. During the 2000 calendar period, a spike in pregnancies occurred in the 20-34 age group, causing a small increase in pregnancies paid. This may be due to the fact that growth in utilization by the Waiver flattened out in the third year of the program. This data is being examined now to discern trends and issues that may need to be addressed. Consistent with other reports, expected teen pregnancies continued to fall in calendar year 2000, resulting in 376 pregnancies averted.

Births averted increased from 114 at the start of the waiver to more than 1,000 by 1999. Again, the largest number of averted births occurred in the youngest age groups. The difference in births averted and pregnancies averted is due to variation in the number of women receiving pregnancy services that resulted in the use of delivery services. Based on expert opinion, the percentage of pregnancies not resulting in deliveries is estimated to vary from 10-15%.

To estimate the Arkansas Medicaid program cost savings attributable to the family planning waiver, four categories of costs were estimated; prenatal costs, delivery costs, infant first year of life, and disabled infant. The estimate of prenatal costs was applied to pregnancies averted in the cost savings formula and the other three categories of cost to births averted. Costs for disabled infants in the second year of life were weighted by the probability that a child would meet the eligibility criteria for a disabled aid category. Using these criteria the evaluation showed that at the end of the third year of the demonstration, the family planning waiver achieved a net reduction in Medicaid expenditures of approximately $4.7 million. Requesting the Women's Health Waiver include women between 133% and 200% will not only save additional money but will match the Medicaid increase to 200% in maternity services.

A number of limitations apply to the analysis that may result in greater program savings in the future. These program savings could not be included at this point because of data limitations. Methods are currently being explored to overcome these data limitations. The most important limitation of the analysis is the inability to link birth mothers with children in the claims data. The costs of pregnancies and births averted in the youngest age group could be much higher than in the other age groups. The probability of complicated deliveries requiring intensive care services declines with the mother's age thus the cost of averted births would decline with the mother's age. Similarly, the probability of having disabled infant costs in the second year of life may be associated with the mother's age. This analysis is difficult at this time because of the inability to link data. While there appears to be cost offset from the program, the method for calculating costs and savings from the program which delays counting of costs for an extra year makes it difficult to determine what that offset will be in the final analysis. The evaluation team will update figures provided in the interim report as the ability to refine cost estimates improves over time.

II. Special Terms and Conditions

The state shall provide documentation of its compliance with each of the Special Terms and Conditions. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information.

1. **a. All requirements of the Medicaid program expressed in law not expressly waived or identified as not applicable in the award letter, of which these terms and conditions are part, will apply to Arkansas Expansion of the Family Planning Services (AEFPS). To the extent the enforcement of such laws, regulations, and policy statements would have affected State spending without the demonstration in ways not explicitly anticipated in this agreement, HCFA will incorporate such effects into a modified budget limit for the AEFPS1115 Program. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. HCFA will have two years after the determination of the demonstration award date to notify the State that that it intends to take action. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the AEFPS 1115 demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the AEFPS 1115 demonstration in comparison of the State's entire Medicaid program (as measured in aggregate medical assistance payments).**

   All of these terms and requirements have been met.

   b. The State will, within the time specified in law, come into compliance with any changes in Federal law affecting the Medicaid programs that occur after the award date of the demonstration. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending without the demonstration, HCFA will incorporate such changes into a modified budget limit for the AEFPS 1115 Demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the AEFPS 1115 demonstration (e.g., laws affecting sources of Medicaid funding), the State will submit its methodology to HCFA for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Arkansas, HCFA would approve the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Arkansas, HCFA would approve the methodology. Should HCFA and the State, working in good faith to ensure State flexibility, fail to develop within 180 days a methodology to revise the demonstration baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be according to the method applied in non-demonstration States.

There were no changes.

2. **The State shall prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and HCFA during the course of the waiver negotiation and approval process.**

   The protocol was submitted and approved, as required.

3. **The awardee will cooperate fully with HCFA or the independent evaluator, selected by HCFA, to assess the impact of the Medicaid demonstrations. The awardee will submit the required data to the contractor or HCFA.**

   The State has cooperated with the independent evaluator to assess the impact of the Waiver.

4. **The state will submit a continuation application by June 1 of each year.**

   Continuation applications were submitted as required.

5. **The awardee will submit narrative progress reports by 30 days from the end of each quarter. The first quarterly progress report is due October 30, 1997. The fourth quarterly report will summarize the preceding year's activity and serve as the annual report.**

   Narrative progress reports were submitted as required.

6. **Arkansas should submit a draft final report to the HCFA project officer for comments. The awardee for incorporation should consider HCFA's comments into the final report. The awardee should use the HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due by 90 days after the end of the project.**

   Not applicable.

7. **The HCFA project officer or designee will be available for technical consultation at the convenience of the awardee within five working days of telephone calls and within 10 working days on progress reports and other written documents submitted, such as the analysis plan.**

   Not applicable.

8. **HCFA may suspend or end any project in whole, or part, anytime before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. HCFA will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, with the effective date. The budget neutrality test and cost overruns as specified in Attachment B will be applied on the time period through termination without adjustment.**

   The State has complied with the terms of the project.

9. **The awardee will assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The HCFA project officer will not direct the interpretation of the data in preparing these documents and reports.**

   The State has complied with this requirement.

10. **The awardee will develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals within 60 days of the demonstration's implementation. The plan must specify that such information is confidential and it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.**

    Policy and procedures of the Arkansas Department of Health and the Department of Human Services were written to protect the confidentiality of clients. These procedures have been strictly adhered to with participants of the Family Planning Waiver.

11. **Arkansas will notify the HCFA project officer before formal presentation of any report or statistical or analytical material based on information obtained through this cooperative agreement. Formal presentation includes papers, articles, professional publications, speeches, and testimony. During this research, whenever the principal investigator determines that a significant new finding has been developed, he or she will immediately communicate if to the HCFA project officer before formal dissemination to the general public.**

    This situation has not arisen.

    The final report of the project may not be released of published without permission from the HCFA project officer within the first four months following the receipt of the report by the HCFA project officer. The final report will contain a disclaimer that the opinions expressed are those of the awardee and do not necessarily reflect the opinions of HCFA.

Not applicable.

12. **Certain key personnel, as designated by the HCFA project officer, are considered essential to the work being performed on specific activities. Before altering the levels of effort of the key personnel among the various activities for this project, or to diverting those individuals to other projects outside the scope of this award, the awardee will notify the HCFA project officer in advance and will submit justification (including name and resume of proposed substitution) in sufficient detail to permit evaluation of the impact on the project. No alteration or diversion of the levels of effort of the designated key personnel from the specified activities for this project will be made by the awardee without the approval of the HCFA project officer.**

    No personnel were designated.

13. **At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must submit to HCFA an analytic data file(s), with appropriate documentation, representing the data developed/used in end-project analyses generated under the award. The analytic file(s) may include primary data collected, collected or generated under the award and/or data furnished by HCFA. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the principal investigator and the HCFA project officer, must deliver any materials, systems, or other items developed, refined or enhanced during or under the award to HCFA. The awardee agrees that HCFA will have a royalty-free, nonexclusive and irrevocable rights to reproduce, publish or otherwise use and authorize others to use the items for Federal Government purposes.**

    No requests have been made.

14. **At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must deliver any materials, systems, or other items developed, refined or enhanced during or under the award to HCFA. The awardee agrees that HCFA will have royalty-free, nonexclusive and irrevocable rights to reproduce, publish or otherwise use and authorize others to use the items for Federal Government purposes.**

    No requests have been made.

15. **HCFA reserves the right to unilaterally terminate the demonstration and the accompanying federal matching authority provided if it determines that continuing the demonstrations would no longer be in the public interest. If a family planning demonstration is terminated by HCFA, the State will be liable for cumulative costs under the demonstration that are in excess of the cumulative expenditures and cost overrun targets specified in the Attachment B for the demonstration year of withdrawal.**

    This has not happened.

16. **a. To track expenditures under this demonstration, Arkansas will report net expenditures in the same manner as is done under the current Medicaid program. The State will provide quarterly expenditure reports using the form HCFA-64 to separately report expenditures for those receiving services under the Medicaid program and those participating in the Expansion of Family Planning Services, Arkansas Medicaid demonstration under section 1115 authority. HCFA will provide Federal Financial Participation (FFP) only for allowable demonstration expenditures that do not exceed the predefined limits as specified in Attachment B. Demonstration participants include all individuals whose service expenditures are subject to the demonstration cap.**

    This condition has been complied with.

    b. Arkansas will report demonstration expenditures through the Medicaid Bureau expenditure Survey, following routine HCFA-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual. In this regard, demonstration expenditures will be differentiated from other Medicaid expenditures by identifying on forms HCFA-64.9 and/or 64.9p with the demonstration project number assigned by HCFA (including the project number extension indication the demonstration year during which services were rendered). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For cost settlements not attributable to this demonstration, the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The reporting procedure outlined above must be approved by HCFA as part of the protocol.

    This condition has been complied with.

c. All claims for the Arkansas Expansion of Family Planning Services Demonstration services provided during the demonstration period (including any cost supplements) must be made within two years after the calendar quarter in which the State made the expenditures. During the period following the conclusion or termination of expenditures using the procedures addressed above. The procedure related to under this reporting process must be approved by HCFA as part of the protocol referenced in Item 2 of the Special Terms and conditions.

The state has complied with this requirement.

Besides the form HCFA-64, the State will provide to HCFA quarterly the number of eligible member/months for demonstration participants. This information should be provided to HCFA 30 days after the end of the quarter.

Quarterly reports have been submitted as required.

17. **The standard Medicaid funding process will be used during the demonstration. The State must estimate match able Arkansas Medicaid demonstration expenditures on the quarterly form HCFA-37. The State must provide supplemental schedules that clearly distinguish Medicaid expenditure estimates. HCFA will make Federal funds available each quarter based upon the State's estimates, as approved by HCFA. Within 30 days after the end of each quarter, the State must submit the form HCFA-64 quarterly Medicaid expenditure report, expenditures reported on the Form HCFA-64 with Federal funding previously made available to the state for that quarter, and include the reconciling adjustment in a separate grant award to the State.**

    These terms and conditions have been met.

18. **HCFA will provide FFP at the applicable Federal matching rate for the following subject to the limits described in Attachment B:**

    a. **Administrative costs associated with the administration of the Arkansas Expansion of Family Planning Services Demonstration.**

    b. **Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan. HCFA will provide FFP for medical assistance payments with dates of service before and during the operation of the section 1115 demonstration.**

c. The State will certify state/local monies used as matching funds for demonstration purposes and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

These conditions have been complied with.

III. Evidence of Beneficiary Satisfaction

Patient satisfaction surveys have been completed in a number of local health units. These were not designed solely to evaluate client satisfaction with the Family Planning Waiver. However, they address a number of issues affecting client satisfaction with various aspects of services provided by local health units including family planning. Results indicate that clients are generally very satisfied with the services they receive in local health units. Factors on the one page survey include privacy, convenience of the location of the health unit as well as convenience of hours of service, and availability of needed services. Results also indicated that a significant majority of the clients felt that the staff was friendly and treated them with respect. Another significant finding of the surveys was that most clients believed that in addition to the service they went in for, they received further information regarding health issues and how to lead a healthier life.

Satisfaction Surveys will be an ongoing part of the Waiver program starting in 2003 and bi-annually thereafter. They will be randomly conducted and in addition to questions on ADH services they will include questions on referral for primary care and availability of services through private providers and other community health providers.

Patients referred to other health providers for primary care could be surveyed on their return visit to the Local Health Unit as one way to determine satisfaction with and effectiveness of their services. A referral log will be kept to document patients referred for primary and preventive care services.

Letters of support (Attachment VII) from those working with recipients of family planning waiver services also indicate a high level of satisfaction with the program.

IV. Documentation of Adequacy and Effectiveness of the Service delivery system (Including Subcontractor Performance).

The state shall provide evidence of sufficient availability under the demonstration, utilizing, where possible, Geo-access or other geographically based systems to support this conclusion. Also the State shall provide summaries of provider monitoring or other reports documenting whether services have been delivered in a timely and effective manner.

The interim report from ACHI indicates that there has been an increase in the availability of services to women through the waiver. The state Medicaid program defines "eligible" as persons who have applied and been found eligible for services under the Medicaid program. The number of eligible in the first three years of the waiver exceeded the total projected for the entire demonstration period by 27%. Their report showed that 65,435 women used the services under the Family Planning Demonstration Waiver in the first three years.

An important reason so many women have received services is because there is a strong and growing number of providers participating. Though a number of women receive services from ADH clinics, there are a large number who have been able to access services through private providers. In PY-1, 617 private providers provided family planning services to women eligible under the Waiver. The vast majority of these providers were in solo or group practices (70%); the balance of the service providers were hospitals, Rural Health Clinics, and Community Health Centers. Seventeen laboratories provided services under the program.

By the end of PY-3, the number of private service providers had grown to 718, an increase of 16%. Solo and group practitioners constituted just over 71% in PY-3, about the same as in PY-1. The number of hospitals and laboratories declined while the number of Rural Health Clinics and CHCs increased. This is particularly significant in light of the fact that many of the Arkansas women who need these services live in rural underserved areas.

Attachment VIII *(map)* shows the distribution of private (non-ADH) service providers in the state by county. Analysis shows that the number of providers per county follows the population figures. Those counties with no providers have some of the smallest populations and limited health care providers. The seven counties with over 20 providers are among the most heavily populated in the state. Each has at least one major hospital and the increased number of health care professionals that facilities attract.

Overall the total number of providers increased from 732 in PY-1 to 818 in PY-3, an increase of 11.7% with all of the increase occurring among the private service providers.

The Waiver will pay for an annual exam for each eligible woman and up to three follow-up visits per state fiscal year (SFY), July 1 through June 30. This provision allows the woman to have a true choice of contraceptive methods as well as assurance that she can return to the health care professional for periodic visits and counseling between annual exams. This also increases a woman's opportunity to receive health care for other medical services such as diagnosis and treatment of sexually transmitted diseases. Evaluation of the Waiver indicates that almost two of every three women took advantage of these follow-up visits. If the numbers are adjusted for those women who chose sterilization (5,699 in the three years), the ratio rises to three out of four.

Another important component of the delivery of family planning services to all Arkansas women of childbearing age is through the Abstinence Education Program. The Arkansas Title V Section 510 Abstinence Education Program budget includes $716,000 in income from the family planning waiver. Four hundred sixty five thousand dollars of this amount is directly distributed to sub-grantees to provide community-based abstinence education. The remainder of the Family Planning Medicaid contribution pays for all of the administrative costs of the abstinence education program, costs of the program evaluation, and the abstinence media campaign. The balance of the Abstinence Education Program is funded from the $660,004 Title V abstinence grant (from which no state administrative costs are extracted) and $495,000 in in-kind support from sub grantees.

The Arkansas Human Development Corporation is a community-based organization that provides services to migrant and seasonal farm workers and their families in Arkansas. Money, from the Family Planning Medicaid Waiver reimbursement helps fund this activity. The program is called Promotoras De Salud Health Education/Risk Reduction Project. The Project's target audience is the Hispanic/Latino population living in Pulaski County. They work with the targeted community on the use of public health services; family planning; adolescent/youth abstinence until marriage; HIV/STD's prevention, pre-natal care; early Diabetes and hypertension detection and management; and childhood immunizations. The Health Promoters promote healthy responses to romantic overtures; aid and encourage healthier lifestyles; and provide referral services to health and non-health service providers.

Unwed Birth Prevention is another important element of family planning services that is funded by reimbursement from the Family Planning Medicaid Waiver. The Arkansas Department of Health Unwed Birth Prevention Program funds 15 counties with the highest number of unwed births in the state. Grants totaling $495,00 have been available to local communities for prevention programs. These programs are designed to reduce the number of unwed teen births in Arkansas. Each county coalition is allocated up to $33,000 for unwed birth prevention programs. The coalitions decide what type of program they want in their communities. Technical assistance and evaluation is provided to each county coalition.

Arkansas also benefits from the Birthing Project USA, which reimbursement money from the Family Planning Medicaid Waiver helps fund. It is a national program that uses volunteers to encourage better birth outcomes by providing practical support to women during pregnancy and for one year after the birth of the child. Each pregnant woman receives individual case management.

This includes identifying and coordinating services offered by agencies such as the health department, criminal justice, children's protective services and social services. During pregnancy, the primary focus is on obtaining, understanding, and complying with prenatal care. After birth, the emphasis is threefold: health care, development of resources necessary to maintain health and the prevention of unplanned pregnancies.

V. Quality

The State shall provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, focused clinical reviews and any other documentation of the quality of care provided under the demonstration.

Maintaining ongoing top quality services and programs is a primary goal of both DHS and ADH. Both agencies work to see that quality is maintained by public and private providers alike. As noted in the Report on the Comprehensive Title X Program Review (Attachment IX) prepared by Kathleen Woodall the Arkansas Project Officer for the U.S. Department of Health and Human Services Office of Family Planning, the ADH has had an agency-wide quality assurance plan for a number of years. Visits to local health units are conducted every two years, with interim visits conducted by family planning staff. A standardized, comprehensive quality assurance audit tool is used for all Local Health Units. In addition, the credentialing process for licensed personnel is much more thorough than required by Title X.

The Medicaid Oversight Review Report (Attachment X) of the Arkansas Medicaid Program Section 1115 Demonstration waiver Project in April 2000 addresses a number of issues impacting the quality of the program. The report indicated that the review had found that Arkansas, particularly the ADH and DHS, Division of County Operations (DCO), were committed to making the application process for the family planning waiver as simple as possible. The report also found that the ADH local units did an excellent job of care coordination. This includes providing activities such as appointment reminders, follow-up of missed appointments and monitoring compliance with referrals in order to maintain women of childbearing age in a system of reproductive health care. A history of working with this population has shown that these services are essential to meeting the goals of the program and providing the highest quality of care possible.

Though the vast majority of the findings in the report were positive a few recommendations were made. Those recommendations have been or are being addressed on an ongoing basis by both ADH and DCO.

It should also be noted that a primary goal of the restructuring of the ADH was to improve quality in all areas. Each regional team has a member whose primary responsibility is improving quality at the local level. They are working with women's health and other programs to ensure that quality is monitored on an ongoing basis and that improvement plans are implemented and evaluated. They are also working closely with local communities to help them identify and meet the needs of their citizens. This should be an avenue to increase participation of both women and providers in areas where it is needed.

Another change is that the former Divisions of Perinatal Health and Reproductive Health are now part of the Women's Health Team. This is an important step in broadening the perspective of women's health needs within the ADH.

VI. Compliance with the Budget Neutrality Cap

The State shall provide financial data (as set forth in the Budget Neutrality Terms and conditions) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. HCFA will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so HCFA will take into account the best estimate of current trend rates at the time of the extension.

As stated in objective 6, calculations for cost offsets associated with the family planning waiver follow definitions and formulas approved with the initial waiver application. Table 7.7 in the evaluation provides the initial calculations for budget neutrality. Over the first three years of the waiver, cumulative costs were approximately $23 million while cumulative costs averted reached approximately $18.5 million. Cumulative costs averted were calculated by applying average cost figures to pregnancies and births averted. Because of the one-year lag in calculating cost offsets, however, the family planning waiver is ahead of schedule in reducing Medicaid expenditures. At the end of the third year of the demonstration, the family planning waiver achieved a net reduction in Medicaid expenditures of approximately $4.7 million. Therefore, to date, the waiver has actually done better than budget neutral, it has actually produced savings. The continued collection and monitoring of data will allow the evaluators to see if this trend continues.

A number of limitations apply to the analysis that may result in greater program savings in the future. These program savings could not be included at this point because of data limitations. The most important limitation of the analysis is the inability to link birth mothers with children in the claims data. Methods are currently being explored to overcome these data limitations. The evaluators recommend the use of some mechanism such as a common maternal/birth identifier that could be placed on all claims for the mother and her children to overcome the current data limitation.

VII. Adequacy of Financing and Reimbursement

The state shall provide evidence such as levels of provider participation, cost analyses, or other means which illustrate the adequacy of financing of the demonstration.

Attachment VIII shows non-ADH provider participation in each of Arkansas' 75 counties.

Though the Wavier has allowed for family planning and other primary and preventive services to become available for many Arkansas women who had not had access to these services previously, there are still a large number of women who fall between the cracks of those covered by private insurance and those currently eligible for the Waiver. Many Arkansans do not have access to health insurance. Arkansas has a significant population of uninsured and underinsured. Many Arkansans are employed in seasonal positions that do not offer health insurance. Many others work in small family owned businesses that do not offer an affordable health insurance option for their employees. Therefore, it is evident that in order to meet this need that women up to 200% of poverty need to be able to receive the same services as those women currently served by the waiver. Recently DMS increased the eligibility limit for pregnant women to 200% of the Federal Poverty Level. Increasing the Waiver's income eligibility to the same level will provide access to family planning services to women who might otherwise access Medicaid to pay for unplanned pregnancies.

B. Public Notice

1. To obtain input from all interested parties regarding the possible continuation of its demonstration program, the State shall establish a public notice process in accordance with the provisions published in the Federal Register on September 27, 1994. A public hearing is one of the ways a Sate can meet the public notice requirements.

A notice was printed in the Arkansas Democrat-Gazette on and allowed to run for seven consecutive days. The Democrat-Gazette is the only newspaper in Arkansas with statewide distribution. This notice included a 30-day public comment period and instructions on how to obtain a summary of the waiver application.

2. The State shall provide HCFA summaries of all comments received and respond to any unanswered issues raised in the course of the public notice process.

C. Process to move Current Eligibles to Extension Group

The following plan has been established to move current eligibles to the extension group. Prior to the end of the current Waiver period, participants that have not accessed the waiver services for the last 18 months will be identified. They will be sent a letter requesting a response if they are still interested in the program. No response will be considered a request for case closure. They will then receive a notice that the case will be closed in ten days. If the recipient indicates they want continued services, the case will remain open.

All cases will have eligibility redetermined over the course of the first 24 months of the extended waiver period. ADH staff will obtain information needed for the redetermination as recipients are seen for waiver services and provide the information to DHS. This process will take place for 18 months. Following the 18-month period, the process described above for participants not accessing services in that 18-month period will be repeated. The DHS county office will send any recipients who did not have eligibility redetermined by the end of the 18th month a notice for redetermination. Those redeterminations will be completed by the end of the 24th month.

Any recipient who is determined ineligible under the extension criteria or who does not provide the information needed to establish continued eligibility will be closed for services following appropriate notice.